# EC-1
**Rev July 2007**

## Hawaii Employer-Union Health Benefits Trust Fund
## ENROLLMENT FORM FOR ACTIVE EMPLOYEES

1. Event:

2. Event Date: (MM/DD/YY) _____/_____/_____

**See Instructions on reverse side BEFORE completing this form. Refer to your benefits guide or our website for plan details.**

| 3a. Employee's Last Name, First, M.I. | 3b. Social Security Number (for new enrollees only) or EUTF ID Number: |
|---|---|
| 3c. Mailing Address (❑ Check this box if your address has changed): | 4. If your spouse or Domestic Partner is a State or County Employee or Retiree, please provide their SSN or EUTF ID. |
| 3d. City: / 3e. State: / 3f. Zip Code: | If you are including your spouse or domestic partner in your health benefits plans, please complete sections 5 - 9. |

3g. Marital Status: ❑ Married ❑ Single
3h. Gender: ❑ Male ❑ Female
3i. Birth Date: (MM/DD/YY)
3j. Phone Number – Work
3k. Phone Number – Home

| 5a. Add | 5b. Delete | 6a. Dependents: First Name, M.I., Last Name (if different) | 6b. Birth Date (MM/DD/YY) | 6c. Social Security Number or EUTF ID Number | 7. Relationship | 8. Gender |
|---|---|---|---|---|---|---|
| ❑ | ❑ | | | | | M F |
| ❑ | ❑ | | | | | M F |
| ❑ | ❑ | | | | | M F |
| ❑ | ❑ | | | | | M F |
| ❑ | ❑ | | | | | M F |

**9. Plan Selections, Changes or Cancellations** - Make your selection by checking the box for the appropriate benefit plans below. Select either Self, 2-Party, Family or Cancel/Waive coverage. Choose only one box in each plan section.

| *Plan Section* | *Carrier Selection* | *Self* | *2-Party* | *Family* | *Cancel / Waive* |
|---|---|---|---|---|---|
| Medical Plan<br>Select one plan from this list. Except for RSN Supplemental and EUTF HDHP plans as noted, the Prescription Drug and Chiropractic plan are bundled with the Medical plan. | EUTF PPO Medical (HMA Network, NMHC Drug, RSN ChiroPlan) | ❑ | ❑ | ❑ | |
| | EUTF PPO Medical (HMSA Network, NMHC Drug, RSN ChiroPlan) | ❑ | ❑ | ❑ | |
| | Kaiser Comprehensive HMO Medical and Drug, RSN ChiroPlan | ❑ | ❑ | ❑ | |
| | EUTF HMO Medical (HMSA Network and Drug, RSN ChiroPlan). | ❑ | ❑ | ❑ | |
| | Kaiser Basic HMO Medical and Drug, RSN ChiroPlan | ❑ | ❑ | ❑ | ❑ |
| | EUTF High Deductible Health Plan (HMSA Network, HMSA Drug) | ❑ | ❑ | ❑ | |
| | EUTF Supplemental Medical (HMSA Network), NMHC Drug, RSN ChiroPlan. | ❑ | ❑ | ❑ | |
| | Royal State Supplemental Medical, RSN ChiroPlan | ❑ | ❑ | ❑ | |
| | EUTF Prescription Drug (NMHC)Only | ❑ | ❑ | ❑ | |
| Dental Plan | HDS Dental | ❑ | ❑ | ❑ | ❑ |
| Vision Plan | VSP Vision | ❑ | ❑ | ❑ | ❑ |
| Life Insurance Plan | Standard Life Insurance | ❑ | | | ❑ |

10. **STATE Employees Only (Premium Conversion Plan)** ❑ Enroll ❑ Do NOT Enroll ❑ Change amount ❑ Cancel PCP

11. Comments:

12. Certification (see instructions on back of this form)
**Employee Signature:** _____ **Date:** _____

13. DPO Signature: _____ Received Date: _____ DPO Phone: _____ DPO FAX: _____

| 14. Dept. ID# _____ _____ _____ _____ _____ _____ | 15a. Dept: | 15b. Division/ School: | 16. Barg. Unit: |
|---|---|---|---|

**SUBMIT TO YOUR PERSONNEL OFFICE.**

# INSTRUCTIONS FOR COMPLETING EC-1 FORM

A. Print or type clearly, if form is unreadable it may be sent back to you.

B. **Please submit form to your Personnel Office or Department Personnel Officer (DPO) for verification.**

C. **This form revised July 2007 is to be used for effective dates beginning July 1, 2007 or later.**

D. Sections:

1. Event – To be entered by DPO, please describe the event. For example, Open Enrollment, Birth, Marriage, Divorce, Loss Coverage, Termination, Transfer In, Transfer Out, Address Change, Marital Status Change, Retirement, Rehire, New Hire, Death, Change in Student Status, Add Dependent, Cancel etc. If there are simultaneous events, please describe the most prevalent event. For example, if the event is a birth and address change, enter Birth in the event section.
2. Event Date – To be entered by DPO, please enter the date the event took place or 7/1/07 for Open Enrollment 2007.
3. Enter Employee's information. For 3b, enter the EUTF ID #. If you are a new enrollee, you **must** enter your social security number.
4. Enter EUTF ID # of Spouse or Domestic Partner if a State or County Employee or Retiree. In addition, complete sections 5 - 9, if enrolling spouse or domestic partner in any of your health benefit plans.
5. Check add box to add dependent, check delete box to delete dependent.
6. Enter Employee's Dependent(s) data. If enrolling your dependent for the first time, enter the birth date and social security number. Otherwise, you may leave the items 6b and 6c blank. If making changes to your dependent's data, enter the corrected item.
   If listing more than 5 dependents, write "Continued" on the last line of the Dependent section. Use a separate sheet of letter size paper to list additional dependent(s) information.
7. Use the following codes for Relationship column:
   **SP** = Spouse **CH** = Child **DC** = Disabled Child√√
   **DP** = Domestic Partner√ **DPC** = Domestic Partner Child√
   **For Relationship codes with √ or √√, please see item #17 below for other required forms.**
8. Gender – circle either M or F.
9. Plan Selections (See the Open Enrollment Benefit for plan coverage summaries). Select one plan from the Medical plans and the appropriate coverage for you. If you do not want any medical plan coverage, mark the "Cancel/Waive" box. To be eligible for a Supplemental Medical plan coverage, you must have other medical coverage from another source, .not sponsored by your employer.
10. Premium Conversion Plan (PCP) – this section is for State employees only. Select Enroll, Do Not Enroll, Change amount, or Cancel. PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pre-tax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. The PCP-2 form is not required for Open Enrollment. For all other qualifying events, please inquire with your DPO or DHRD on completing a PCP-2 form.
11. Comments – use this section for your comments. If additional space is required, please attach a separate sheet of letter size paper.
12. **Certification**
    Signature of Employee certifies that the information provided in this application is true and complete. Employee agrees to abide by the terms and conditions of the benefit plans selected. Employee authorizes their employer or finance officer to set the effective dates of coverage and to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations. Employee affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student. Employee affirms that they have non-EUTF plan benefits for each Supplemental Coverage Plan selected. Employee signature also affirms that they have read and understood the PCP section in the Health Benefits Reference Manual.
    Please enter date of Employee's signature.
13. DPO signature certifies applicant is eligible as defined in Chapter 87A, HRS. Enter date the EC1 was received from the employee. It's the date that the employer receives the form, not when the DPO receives it. DPO – Please provide your phone and fax numbers.
14. Department ID code – DPO, please enter your appropriate Department ID code. For example, 010021 for Department of Education, 010022 for University of Hawaii, 040028 for City and County of Honolulu Emergency Services, etc.
15. Dept: and Division/School: - Optional fields for DPO use only.
16. Bargaining Unit number – DPO, please enter the appropriate bargaining unit for this employee.
17. Other EUTF forms to include with EC-1 (if applicable):
    √Domestic Partnership Declaration or Termination
    √ DHRD Domestic Partner PCP Acknowledgement Form (State Employees with PCP enrolling Domestic Partners)
    √Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
    √√D-1 (5/2003) for enrolling disabled child
    DHRD PCP 2 form (For State Employees Only)